

DR PHILIP A BERK
MBBCh FCRAD(DIAG)S.A.

IMAGING / PROCEDURE REQUEST

Date: _____

Patient Name: _____ Medical Aid: _____

Tel: _____ Referring Doctor: _____

Clinical Details: _____

Please tick requested study / procedure

Thyroid / Head & Neck

- Thyroid Ultrasound
- FNA
- Neck / Lymph Node Ultrasound
- Salivary Gland Ultrasound
- Thyroid Cyst Aspiration
- Thyroid Nodule Ablation / RFA Assessment

Other Imaging

- General Ultrasound
- X-Ray

Doppler / Vascular

- Carotid Doppler
- Venous Doppler (DVT)
- Arterial Doppler
- Other Doppler: _____

Ultrasound-Guided Procedures

- Joint Injection
- Aspiration / Drainage
- Core Biopsy
- Other Ultrasound-Guided Procedure: _____

Site / Area (if needed): _____

Reports emailed to referring doctor

Signature: _____